C+D

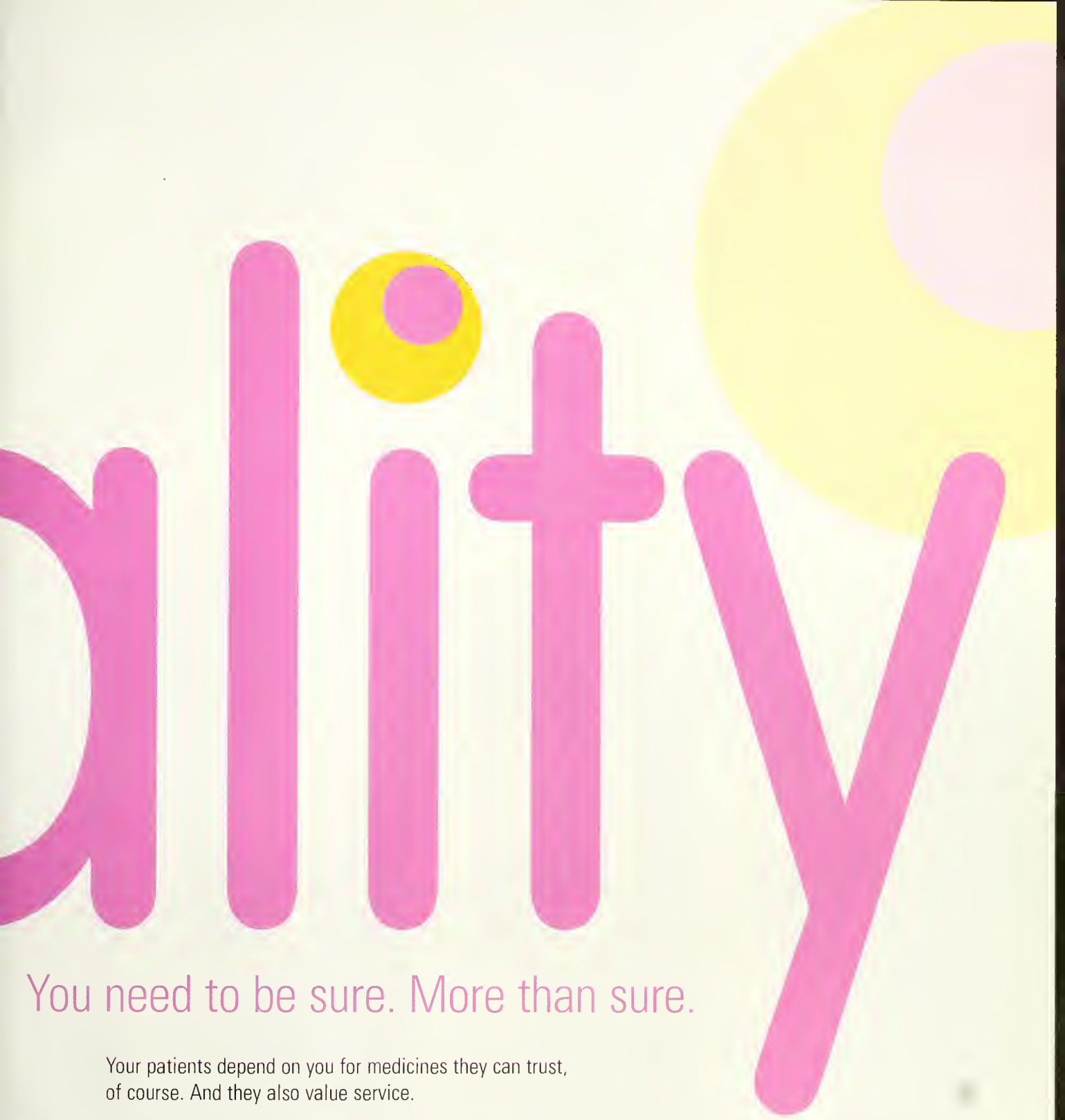
30 June 2007

Chemist+Druggist
The newsweekly for pharmacy
www.dotpharmacy.com

C+D takes Stop the Switch to the MHRA

MPs seek funds for public health roles in pharmacy contract

- Pharmacy staff rescued from floods
- Robotic dispensing: rise of the machines



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C+D

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CMP

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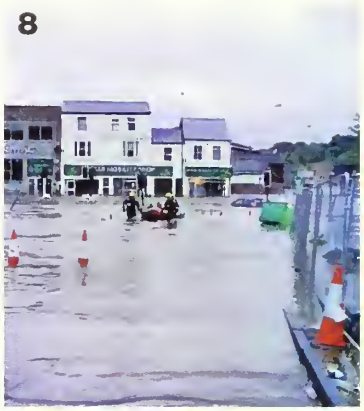

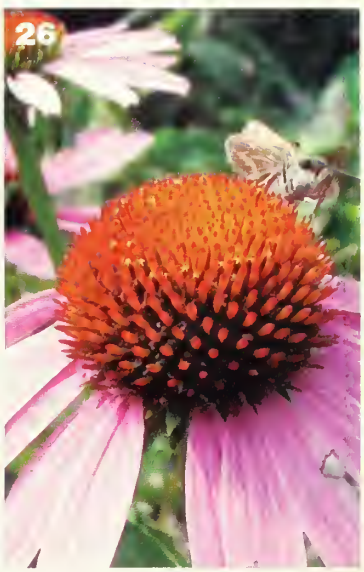

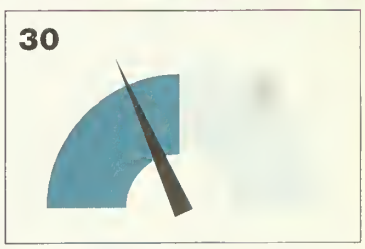

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MPs: pay up for public health role

All-party pharmacy group report calls for more cash to support extra work demands

Jennifer Richardson

Pharmacy needs more money to tackle public health problems, MPs said this week, but the profession must also do more to help itself.

Following a year-long inquiry, the all-party pharmacy group said the contract's advanced services tier should include managing patients with long-term conditions and minor ailments, chlamydia screening and advice, diabetes and other diagnostic screening services, and obesity and weight management.

"These advanced services should be funded from within the nationally agreed sum for community pharmacy services," said the group's report, "thus requiring an uplift in that sum."

The report found failings in professional leadership, with MPs calling on pharmacy to present a united public front. "The national organisations should, wherever possible, speak with one voice, so that the government knows what you're saying as a profession," APPG chair Howard Stoate MP told pharmacy representatives at the report's launch this week.

PCTs also came under attack from the APPG. "The idea that PCTs can be left to commission services is just not working," Dr Stoate said. "There should be a national agreement so we get over the problem of reinventing the wheel in each PCT," he added.

APPG treasurer Sandra Gidley MP called on pharmacists to carry the report's findings forward. "You can't rely on a few parliamentarians doing this alone – if the profession doesn't get on board then we'll all be wasting our time. There needs to be more proactivity from grassroots pharmacists," she said.

Pharmacy must speak with one voice to gain respect from government, Howard Stoate MP said at the launch of the APPG report this week

Poor relations with GPs are another major barrier to service development, the 86-page report concluded. "We found that GPs are resistant to change, territorial and sometimes resentful of pharmacy," said Dr Stoate. "There is a shocking lack of collaboration between GPs, PCTs and pharmacists."

The report recommends GPs be given quality and outcomes framework points to reward them for working constructively with pharmacists. The government should also consider a QOF-style system for community pharmacy, the APPG suggested. "We believe pharmacists should be much more remunerated on quality of service instead of on volume," explained Dr Stoate.

Pharmacy minister Lord Hunt confirmed that the Department of Health would respond to the report. "I can promise you, we really do want to have a constructive discussion with you," he said.

To read the full report, 'The Future of Pharmacy', visit http://tinyurl.com/yseewh

What do you think of the report's findings?
haveyoursay@cmpmedica.com

Pharmacy blueprint: the report's key findings

Services
- More nationally agreed funding for advanced and essential services.
- Less discretionary funding by PCTs for enhanced services.
- Six additional advanced services: managing patients with stable long-term conditions; chlamydia screening and advice; managing minor ailments; diabetes and other diagnostic screening; and obesity and weight management.
- DH to facilitate repeat dispensing services and draw up a community pharmacy out-of-hours action plan.

Finance
- 2008-09 should include a new quality reward mechanism, including a quality and outcomes framework (QOF).
- Guidance to encourage practice-based commissioning.

Collaboration
- Financial incentives in the general medical services (GMS) contract to encourage collaborative working.
- New pharmacy referral criteria, joint continuing professional development (CPD), LPC-led local stakeholder engagement plans.

Image
- Contractors to display the NHS logo.
- DH to lead a community pharmacy awareness campaign.

Leadership
- LPCs to agree three-year objectives, with a current year action plan.
- LPCs to employ a secretary or chief executive to encourage and support service development.

NHS reorganisation
- Endless review of pharmacy location regulations should cease.

Access
- Consistency in PCT decision making.
- Financial incentives for pharmacies that open in economically unviable areas at a PCT's request.
- Monitoring of control of entry exemptions or the removal of those that fail to improve access.
- A nationally-defined performance evaluation system that reflects national criteria and local needs.
- Further increase in the role of dispensing technicians.

IT
- Role based read-write access to the NHS Care Record, and a supporting publicity campaign.

Education
- Collaborative, practical training involving pharmacists, medical professionals and nurses.
- Practical independent prescribing experience for undergraduates.
- Financial reimbursement for CPD.

A

Royal College to forge future success

Jennifer Richardson and Ailsa Colquhoun

Pharmacy representatives are pinning their hopes on a new Royal College of Pharmacy to provide the strong leadership that will secure the profession's future.

In response to a finding in the APPG inquiry that pharmacy has the opportunity to forge a greater presence in the healthcare community, RPSGB president Hemant Patel said the royal college will have "a key role to play".

He said: "We must engage more with professional bodies, the Department of Health and other pharmacy bodies to deliver the proposed national communications campaign."

Paul Bennett, chair of the RPSGB's English Pharmacy Board, said the various pharmacy organisations needed a single voice. "On the really critical issues it's important to be united so the government gets a very strong message from pharmacy."

Mr Bennett added that he had concerns with the way services are commissioned. "The proposal for nationally agreed but locally implemented advanced services would imply there are common standards across England. That's very important, in terms of what patients would receive but also what pharmacists can deliver," he said.

The NPA, echoing the RPSGB's call for greater collaboration with other healthcare professions, backed the APPG's demand for a forum for joint strategic discussion between representative bodies.

Acting chief executive Colette McCreedy said: "It is for community pharmacists themselves to make a decision about which organisations represent their interests best. The recommendations contained within this report are in the gift of the pharmacy bodies to deliver."

The NPA also supported the APPG's call for effective monitoring of the control of entry exemptions, and for pharmacists to be present on the premises for the overwhelming majority of a pharmacy's opening time.

PSNC chief executive Sue Sharpe said current priorities are the development of new national services, particularly public health services such as obesity and sexual health, and minor ailments. However, she voiced concern that commissioning was not happening quickly or consistently enough.

Commenting on the remuneration aspects of the report, Mrs Sharpe said: "The QOF [proposal] is interesting and one that PSNC will consider and discuss with the DH."

Hemant Patel: professional leaders must talk more

LPCs reject weakness claims

An LPC secretary has reacted angrily to claims by MPs that some local committees are weak and lack professionalism.

Damning the APPG report as having "little grasp of the actualities of pharmacy and PCT interaction", David Kent, secretary of Camden & Islington LPC, said: "It is difficult to achieve anything on a day-to-day basis let alone look at longer term objectives. The LPCs have to grasp at initiatives as and when opportunity arises. In terms of pharmacy, long-term means achieving a second year funding."

Other LPCs also said the APPG report fails to recognise the scale of local difficulties. Dorset LPC secretary Roger King, said: "We can only take the horse to water and give it the opportunity to drink. We are often frustrated too, but that doesn't mean we are not doing anything. Sometimes it is difficult even to get the door open a crack."

Mr King added that it was "time to look at getting the right people in the right place" for a royal college.

Janet Ward, Leeds LPC secretary, applauded the report's conclusions but warned that implementation would be challenging at local level. "Leeds LPC has already adopted as [its] goals the principles set out in the recommendations. However, this has increased workload and financial demands with daytime meetings."

Views on the APPG report

"I think they hit the nail on the head with talking to PCTs and doctors – communication is going to be key to moving on"

Lindsey Gilpin, English Pharmacy Board

"By using the skill mix in the right way they've got a better chance of moving what they've planned forward"

Sarah Wilcox, president of the Association of Pharmacy Technicians UK

"I think the way forward is to get a discussion group together, to include PCTs, GPs and pharmacists, to really thrash out how we can move forward very quickly on most of these recommendations. Let's look to the best of the best around the country and use those examples to get change"

Peter Gibson, Alliance Boots head of public affairs

"I think it's a very useful report. It handles a lot of issues that have been raised by other pharmacy bodies, but it depends what the actions are that follow on from it"

Heidi Wright, RPSGB head of quality improvement

"It's going in the right direction but it needs to be joined up. There are so many vested interests that it's difficult to see the wood for the trees sometimes. Less fragmentation of the profession is needed. If they all speak together it would make it a lot easier"

Andrew Smith, Patient Dynamics survey director

Goldshield pays £4m to settle price fixing claims

Drugs firm foots bill for alleged cartel conduct without accepting liability

Ailsa Colquhoun

Goldshield Pharmaceuticals and Forley Generics have paid the Department of Health £4 million to settle, without admitting liability, claims that the companies fixed prices in relation to supplying generics to the NHS.

As part of the settlement, the companies have pledged to cooperate with the DH over its other continuing civil cases relating to the alleged abuse of prices of warfarin, penicillin-based antibiotics and ranitidine.

The Department said it looked forward to "a strong working relationship" with Goldshield.

So far, the DH has recouped £34m from seven generics suppliers alleged to have acted anti-competitively in the supply of warfarin, penicillin-based antibiotics and ranitidine to the NHS.

In 2005 Ranbaxy settled for £4.5m. Generics UK also settled the same year, for £12m, ending its proceedings in relation to ranitidine. Norton Healthcare followed suit in 2006, paying £13.5m to settle.

All four companies that have settled with the DH have done so without admission of liability.

The remaining defendants are Kent Pharmaceuticals, for alleged price fixing in the supply of all three drugs; DDSA Pharmaceuticals, for alleged price fixing of penicillin-based antibiotics; and Regent-GM Laboratories, for its alleged involvement in warfarin and penicillin price fixing.

Pharmacists in the Wicker area of Sheffield were rescued by boat late on Monday when the River Don broke its banks. But after a night in a local hotel, staff were back at 6am to start cleaning and by 8.30am the pharmacy opened as usual. Martin Bennett, managing director of the Wicker pharmacy, said they still only had a third of the power supply and a lot of damaged stock but the staff had done a "fantastic job". See more next week

Have you been flooded? Tell us and send in your photos
mgosney@cmpmedica.com

Error logs best practice updated

The Royal Pharmaceutical Society has revised its rules on single dispensing errors amid fears that record logs could be used as the basis for disciplinary action.

In an updated Law and Ethics bulletin, the Society's Council emphasised that keeping a medication error log is seen as evidence of "good practice" and should be included in standard operating procedures.

Where a pharmacist has recorded an error and admits blame, they are likely to be dealt with by the Society's inspectorate without referral to the Investigating Committee.

The Society added that where a log records changes to operating procedures to avoid the repeat of an incident, then it could be "particularly helpful" to an investigation.

In contrast, the failure to keep a log has been listed as one of 14 criteria that could determine whether a single error is deemed professional misconduct and warrants referral to the Investigating Committee.

The guidance also makes it clear that inspectors might ask for evidence of error logs during routine inspections but "will not usually" look at the records or use the information.

Error logs, the Society said, would only be examined where concerns had been raised about the fitness to practise of a pharmacy or individual and "where there was genuine cause for concern about public safety".

The Law and Ethics bulletin can be read at www.dotpharmacy.com/law_and_ethics.html **TH**

News in brief

Code of Ethics online

The finalised version of the Code of Ethics for Pharmacists and Pharmacy Technicians will be available from the RPSGB website from July 1, ahead of August 1 when it comes into force. The code is designed to promote 'a culture of accountability and professional judgement', and to apply similar principles to both pharmacists and technicians.

Waste rules risk

Scottish pharmacies could scrap medicine disposal services in a row over waste removal rules, the NPA has warned. The Waste Framework Directive places unnecessary administrative burden on contractors, the association said.

EPS release 2 test sites

Five PCTs have been selected to pilot release two of the electronic prescription service. Berkshire East, Leicestershire County and Rutland, Southwark, Sunderland and Liverpool will go live on October 1.

Education review

The University of Birmingham will lead an independent review of the Centre for Pharmacy Postgraduate Education. The study will investigate whether CPPE meets professional development needs.

Epilepsy failures

Failures in the management of patients with epilepsy are causing 400 avoidable deaths a year, according to a report by a parliamentary group on epilepsy. The report claims 69,000 patients have preventable seizures, while 74,000 take drugs they do not need.

NPA's new chief executive

A former Royal Mail director has been named chief executive at the NPA. Alison White, whose CV also includes senior posts at business advice and healthcare firms, pledged "service excellence and innovation" after her appointment.

No to P med self-selection

The RPSGB is to issue guidance on the display of P medicines, after its decision to maintain the need for professional intervention during a sale. Council agreed that P medicines should not be available for self-selection, but believes that this does not preclude methods of display which allow patients to better view P medicines.

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The Serious Quitters booklet will help to inform smokers about many aspects of stopping smoking – from the well-known health benefits to the range of different treatment and support options now available on the NHS. The free booklet will be available to download from the website: www.seriousquitters.co.uk.

Better informed smokers will be able to have a focused and meaningful discussion with you, so that together, you can identify the stop-smoking plan that is right for them.

If you would like to order your free supply of Serious Quitters booklets, call freephone 0800 092 4442 now.

Helping your *SERIOUS* QUITTERS become a part of the new smoke-free Britain!

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For more on the Stop the Switch campaign see:
www.dotpharmacy.com/stoptheswitch

Industry rallies behind MPs over switch plan

Report on pseudoephedrine issue finds widespread support

Jennifer Richardson

A pharmaceutical industry leader has labelled the proposed P to POM switch of pseudoephedrine 'plain wrong".

John Harold, outgoing PAGB president, urged the government to work with industry to tackle crystal meth abuse. "It just seems plain wrong for millions of people to lose access to a safe and effective medicine," he said at the association's annual dinner.

Mr Harold claimed the all-party parliamentary groups' report, which advised against the switch (C+D, June 23, p4), added important political support to pharmacy's fight against reclassification.

Other pharmacy representatives also rallied behind the APPG findings.

Michelle Styles, the NPA's acting director of pharmacy practice, said the groups' report was well-balanced. "They've made a rational recommendation, which is that the proposed switch is highly disproportionate to the perceived threat."

The main advocates of the reclassification were anti-crime agencies, said Ms Styles, who were wrong to use US evidence in support of reclassification because pseudoephedrine had until recently been on the general sales list there.

C+D's news editor Max Gosney delivered a 1,500 signature petition to the MHRA

However, police officials endorsed closer working with pharmacy as a way to counter abuse. A spokesman for the Association of Chief Police Officers said: "Whilst making [pseudoephedrine] prescription-only is one effective option, we also welcome the all-party joint inquiry recommendations to reduce pack sizes, limit sales and tighten pharmacy control."

The comment came as the MHRA closed its consultation on reclassification. C+D presented it with more than 1,500 names in support of the Stop the Switch campaign. In addition, GlaxoSmithKline collected nearly 1,000 signatures from its customers in just six weeks.

Pharmacy robots: the rise of the machines
See page 33

Beat the postal strike

If delivery of your C+D has been delayed by the postal workers' strike, ensure you don't miss out on the C+D headlines by signing up for our free weekly email news bulletin at www.dotpharmacy.com/newsbulletins

Everyone who registers by July 7 will be entered into a prize draw for a Krups expert coffee machine.

News in brief

Piroxicam changes

EMEA has issued new prescribing advice with respect to oral, injectable and suppository forms of piroxicam, after reports of serious gastrointestinal and skin reactions.

Doctors and patients are advised to take no urgent action, but patients who have previously received piroxicam for short-term use should receive an alternative medication in future.

OTC chlamydia drug?

An application for an over the counter oral antibiotic treatment for chlamydia has been put to the government's health watchdog.

Actavis is seeking to make azithromycin 500mg tablets available as a pharmacy medicine to treat known or suspected asymptomatic chlamydia infection for patients aged 16 and over.

The application for reclassification suggests that it should be accompanied by a pharmacy service model in which only individuals with a positive result for chlamydia would be able to purchase the antibiotic.

The model would require a positive result using the gold-standard NAA test, and would not accept the EIA or home wand tests, which the document describes as sub-optimal .

The proposed model also includes options for the management of sexual partners, who could be eligible to receive treatment after either testing positive, or after consulting with the pharmacist and showing that they also meet the protocol supply criteria.

The pharmacy model would be adaptable to fit with existing local policies.

The consultation will run until August 2, and the full proposal can be found at the website of the Medicines and Healthcare products Regulatory Agency at www.mhra.gov.uk

Is echinacea an effective cure for colds?
See page 26

PSNI ballot on future

Six options for the future of pharmacy regulation and leadership in Northern Ireland are being put out for consultation to get feedback from the profession's grass roots.

The Pharmaceutical Society of Northern Ireland is asking members for their views on six choices of how pharmacy should respond to the issues raised by the White Paper Trust, Assurance and Safety. The responses will inform PSNI's recommendation to the health minister. The options are:

- No change.
- PSNI to maintain a dual role but with increased separation between the activities.
- A GPC and royal college body exclusively for NI.
- NI to be subsumed into the GB model.
- PSNI as regulator and a UK royal college to lead.
- PSNI to lead with a UK GPC as regulator.

The choices were set out in an extraordinary general meeting on June 21, where president Raymond Anderson expressed disappointment that response from the profession had been poor to date, despite PSNI's effort to aggregate views on government plans to separate regulation from leadership.

He added that the Council had a duty to back a stance that had wide support rather than decide the profession's fate.

At the session, registrar Brendan Kerr emphasised PSNI's unique position and argued that a local regulator could better respond to an cross-border problems. **Contribute**

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Pharmacy Champions

Pharmacy Champions

David Wildman

Pharmacy
Co-op Pharmacy, Rothwell, Northants

What has he done?
Set up a free weight management clinic

What have you set up?
We set up the scheme with the help of our local Roche representative, Amanda Woolgrove, as a pilot for the Co-operative Group. Between us we designed a protocol for referral to the GP for patients with certain co-morbidity risk factors or very high BMIs, and for patients who achieve a certain weight loss over a period to be reviewed for anti-obesity drugs. This was agreed with our local GP practice before we embarked on the service.

All clients start off with a weigh-in, waist measurement and BMI calculation. We then offer a four-week cycle where they come in once a week for one-to-one counselling and a weigh-in. Each week has a theme, such as healthy eating, how to exercise more, how to read food labels and an overview of food types and portion sizes. We don't offer a diet as such, just encourage healthy eating and offer lifestyle advice. After the four weeks we offer a weekly weigh-in and encourage clients to keep up the good work.

What has been the high and low point of setting up the service?
The obvious highs are when clients achieve their goals. We had one young woman who wanted to lose weight for her wedding. We supported her over a three-month period and had one very satisfied and svelte bride.

Another high point has been seeing how my staff have developed. After the initial training, Elaine Diack and Nikki Styles showed an interest so I encouraged them to progress further. They now do most of the counselling, advice and encouragement.

It's great to see how confident all the staff have become, how they are embracing CPD generally and how they have benefited from their new roles and responsibilities.

We got quite a buzz when our scheme was rolled out to the rest of the group once we'd streamlined it and smoothed off the corners.

The only negative was on the very first day when we had three appointments, expected a fanfare and had two no-shows. We've since learned not to make appointments unless they are requested by the customer. We've also realised that these services develop their own momentum.

How have the patients and GPs reacted?
The patients have been very positive and we've built up relationships with many of the regulars over the weeks and months. They appreciate our support when they have a bad week. The GPs can also see the benefits.

Do you have any advice for others?
First get as much information about what the market needs, then think about how you will deliver the service. However, the most important thing is to engage your staff. Once they understand what you're trying to achieve it's easy.

Why do you think you have been successful?
Good planning and good training and engagement of staff. We engaged the GPs before starting the service and we made the most of our resources. We also regularly re-evaluate what we're doing and tweak the service if necessary.

Has offering the new service given you greater job satisfaction?
I believe we really make a difference to the long-term health and fitness of our customers, which is gratifying for us all. We are demonstrating that pharmacy can deliver these kinds of services now and in the future.

Staff attitude to change is so much more positive. They gel better as a team. Also, with a weight management service you get feedback on a weekly basis, which is a novelty.

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- For smokers who have used a single form of NRT before but need help to manage breakthrough cravings[3]

for every cigarette, there's a nicorette

Nicorette Patch Product Information: Presentation: Transdermal delivery system available in 3 sizes (30, 20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Initially one 15mg patch daily for 8 weeks. Dose should be reduced to 10mg for 2 weeks and then 5mg for a further 2 weeks. Adults who use NRT beyond 9 months should seek advice from a healthcare professional. **Adolescents (12 to 18 years):** As per adult, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensivity. **Precautions:** Erythema may occur. If severe or persistent, discontinue treatment. Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, generalised dermatological disorders, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response, to adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, itching, urticaria, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. See SPC for further details. **NHS Cost:** 15mg packs of 7: (£9.07). 10mg packs of 7: (£9.07). 5mg packs of 7: (£9.07). **Legal category:** GSL. **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent. CT13 9NJ. **PL numbers:** 0032/0292, 0293, 0294. **Date of preparation:** March 2007. **Nicorette Gum Product Information: Presentation:** Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Mint, Freshmint and Freshfruit flavours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. Used to help smokers ready to stop smoking immediately and also smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** No more than 15 pieces of gum should be used each day. Use when there is an urge to smoke. Patients smoking 20 or less a day should use 2mg gum. Those smoking more than 20 should use 4mg gum. Each piece should be chewed slowly for about 30 minutes. *Smoking cessation:* Patients should stop smoking during treatment. After up to 3 months ad libitum dosage, Nicorette gum use should be gradually reduced. Those who use NRT beyond 9 months should consult a healthcare professional. *Smoking reduction:* Use the gum between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready but no later than 6 months. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** No more than 15 pieces of gum should be used each day. Smoking cessation: After 8 weeks ad libitum dosage, reduce gum use over 4 weeks. If not stopped by 12 weeks, a healthcare professional should be consulted. *Smoking reduction:* Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Oenture wearers, GI disease, unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **NHS Cost:** 2mg gum (10) £2.05, 2mg gum (30) £3.25, (105) £8.89, (210) £14.82; 4mg gum (30) £3.99, (105) £10.83, (210) £18.24. **Legal category:** GSL. **PL numbers:** Original 2mg 00032/0248, 4mg 0032/0249; Mint 2mg 0032/0250, 4mg 0032/0251; Freshmint 2mg 0032/0283, 4mg 0032/0295, Freshfruit 2mg 15513/0136, 4mg 15513/0137 **PL holder:** Pharmacia Ltd. Ramsgate Rd, Sandwich, Kent.CT13 9NJ. **Date of preparation:** March 2007.

References: 1. Puska P, Korhonen HJ, Vartiainen E, et al. Combined use of nicotine patch and gum compared with gum alone in smoking cessation: a clinical trial in North Karelia. Tobacco Control. 1995;4:231-35. **2.** Komitzer M, Boutsen M, Oramaix M, et al. Combined use of nicotine patch and gum in smoking cessation: a placebo-controlled clinical trial. Prev Med. 1995;24:41-47. **3.** Action on Smoking and Health. Guidance for Health Professionals on changes in the licensing arrangements for Nicotine Replacement Therapy. December 2005.

Date of preparation: June 2007

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Comment from the editor

So now we know: GPs are territorial, PCTs are inconsistent when it comes to commissioning pharmacy services, professional leadership is fragmented and pharmacists need to be fully part of the NHS IT structures.

For pharmacists at the coalface, the findings of the all-party pharmacy group's report will come as no surprise. Yes there are pockets of innovation but, in general, community pharmacy is routinely overlooked when it comes to handing out the invites for the primary care commissioning party.

The report calls for public health priorities such as services for minor ailments, obesity management and diagnostic screening to be part of the advanced tier of the contract in England and Wales and also recommends a GP-style qualities and outcome framework for community pharmacy.

Both would be welcome additions in further establishing community pharmacy's role as a health provider. But these suggestions are not new and one wonders how bothered the Department of Health is about developing community pharmacy services.

In the past few years, the DH has consulted on just about everything and anything that moves in primary care and pharmacy's representative bodies have highlighted time and time again the barriers that prevent their members from contributing further, with little end result.

Perhaps GPs are the key issue in all this. They dominate primary care trusts, they have control of commissioning funds and, as a group, are highly adept at promoting their own interests to their paymasters.

The new Prime Minister has already indicated that he wants to see pharmacy contribute more, he now needs to instruct his health secretary to make this happen, and the APPG recommendations would make a good starting point.

Gary Paragpuri, editor

> "The new Prime Minister has already indicated that he wants to see pharmacy contribute more"

Your views

Pfizer must loosen its grip on supply

Too much power in the hands of one manufacturer is not good, says Phoenix Healthcare chief

Pfizer told us that the principal reason for introducing its new supply arrangements was to eliminate counterfeits. We have always been sceptical about this, believing that the real reason behind the new scheme was to limit supplies into the market.

Only months after the introduction of the new arrangements, we now see proof that Pfizer is seeking to impose quotas at pharmacy level.

Letters are automatically being sent to contractors who, in Pfizer's opinion, are ordering more stock than they need. The only way to procure more stock is for affected contractors either to wait until the beginning of the following month or to contact Pfizer and explain why their demand exceeds Pfizer's unilateral estimation.

The reality is, however, that stock demands vary. Different pharmacies will have different stock demands depending upon the prescription volumes they handle or the prescribing patterns of local GPs.

And given that prescribers are generally free to prescribe any product, exact patterns are impossible to predict.

Contractors are obliged to supply, with 'reasonable promptness', any item ordered on a prescription form. It is quite right that they should and so must be able to get hold of product quickly and easily.

The existing supply arrangements have worked well to cope with the variations in demand, with contractors also being able to source from a network of wholesalers should supply problems occur.

The network has also allowed us to deal with quotas in the past and work hard to make stock available throughout the network and thus ensure continuity of supply to patients.

Pfizer's tightly controlled solus supply arrangements have removed this flexibility from the system. It is now down to the manufacturer – rather than the choice of patients and practitioners – to determine who gets what and by what route.

This cannot be right. Please don't misunderstand me. I am not opposed to change. I also recognise that the old adage 'you don't know what you've got till it's gone' is perhaps oversentimental. But putting so much power into the hands of a single manufacturer seems to be wholly undesirable.

The provision of medicines in a timely manner is a key component of healthcare services. The existing system has evolved well to ensure that patients get the medicines they need when they need them and at a price that the taxpayer can afford.

What Pfizer is doing – and make no mistake, others will follow suit – will seriously undermine the ability of providers of healthcare services to continue to provide that service in a way that puts the patient first and keeps administration to a minimum. We cannot allow this to happen.

The OFT is currently conducting a review on the Pfizer scheme. This is welcome, but will take time. In the meantime, there is a serious risk of irreversible damage being done to the supply chain.

Urgent action is therefore needed now.

In addition to responding to the OFT inquiry, I urge all of you to make your concerns known to the Department of Health as a matter of urgency.

Paul Smith
chief executive
Phoenix Healthcare

Your views

Pfizer: New scheme given 'full visibility'

It is surprising to note that Phoenix is sceptical about Pfizer's decision to provide a safe and secure channel for pharmacists to receive genuine medicines from Pfizer, when in the last month there have been four separate MHRA 'Class 1' drug recalls following the discovery of counterfeit product in the UK supply chain.

It is critical for Pfizer that every UK pharmacy is able to buy supplies of our medicines to meet their patients' need, that's why we have a team dedicated to ensuring we bring sufficient product into the UK so we can always meet demand.

Our team uses a variety of mechanisms to forecast demand for Pfizer prescription medicines, similar to those of other wholesalers, to ensure that pharmacies have more than enough stock to meet patient needs. In over 99.7 per cent of cases, we have supplied pharmacies with Pfizer prescription medicines to fulfil their

> "On a few limited occasions, we have had to directly manage highly irregular or unusual orders"

orders. However, on a few limited occasions, we have had to directly manage highly irregular or unusual orders that may compromise our ability to ensure continued availability to all UK patients.

Our new arrangement allows us full visibility of the supply chain from factory to pharmacy, which enables us to make sure we distribute our medicines fairly and evenly to all UK pharmacies. In addition, Pfizer does not have the needs of a wholly-owned pharmacy chain to consider.

If pharmacists have any concerns regarding our new arrangements, they should contact the Pfizer team on 0845 608 8866.

David Watson,
director of trade, Pfizer

Xrayser

Xrayser CD

Only the GPs remain to be won over

If only we could get the GPs on our side there should be nothing but ourselves preventing us from reaching our pharmacy utopia.

We are getting increasing backing from government, we have recently had good mentions from MPs of both parties, all-party parliamentary groups support our 'Stop the Switch' campaign, and the Welsh Assembly Government endorses an expanded role for pharmacists (C+D, June 23, p4,5,8). Admittedly actions speak louder than words but we must hope that at least some action will follow.

The only group which wants to diss our efforts and limit further contributions are the GPs (C+D, June 23, p5). There are isolated pockets of cooperation and encouragement but generally their view seems to be that if they can convince themselves that we have no useful contribution to make then everyone else will believe it too.

Everyone agrees that MUR paperwork needs improving, but to say that MURs are "completely useless" is simply not true. Just ask some patients whether they think their time was wasted. And to say that MURs are not cost-effective reveals a misunderstanding about how they are funded. They are fundamentally a freebie because we're not paid any more in total since we've been doing MURs than we were before.

CD

Xrayser CD

This smacks of protectionism on the GPs' part; it's a policy that's always served them well and put them in their current very powerful position. But policies need to be updated as times change and this one is no different. If we can keep bringing influential people round to our way of thinking, the GPs run the risk of becoming isolated. They alone will not be able to stop us expanding our role in a meaningful way.

I don't want to be a GP. I have no interest in physical examinations and difficult diagnosis. Nor do I have any intention of depriving them of their hard earned income. There are lots of ways I can help local GPs to our mutual benefit and if they can take that on board they can reduce the risk of appearing simply as self-centred obstacles to progress.

Nothing is ever free, including prescriptions

I can't wait to see what the Department of Health's soon to be published review of prescription charges comes up with.

I suspect that there won't be any dramatic changes but Scotland's decision to follow the Welsh lead in abolishing prescription charges altogether (C+D, June 23, p6) must have increased the pressure to make some sort of significant gesture. Or maybe not. The current system is flawed but I can't think of any system that would be flawless.

It's not ideal that people have to pay the charges but somebody has to pay for the NHS and if it's not people receiving prescriptions it must be someone else. It must be nice for Scottish people to think they are getting prescriptions for free while we're not, but who do they think will make up the £46 million that used to be collected every year in charges? That £46m could pay for a lot of operations or even a new hospital or two. Personally speaking, I like to think my £6.85 goes to a good cause and is a small price to pay for a reasonably well functioning health service. I wouldn't vote for any changes that cost the NHS.

24 tablets inside

Intensify your sales with New Vaseline Intensive Rescue

- New range from Vaseline designed for the driest skin
- £3.5m integrated support package
- Targets £71 million dry skin treatment sector

Vaseline

New Vaseline Intensive Rescue.
Very dry skin can fight back.

Your letters

Recent error log developments

I am writing further to the publication of the article entitled "Law firm's error log warning" (C+D, June 16, p6).

While the Royal Pharmaceutical Society cannot comment on the individual cases referred to in the article, we have issued a Law and Ethics Bulletin (LEB), clarifying the issues involved in the use of medication error logs (see page 8). This LEB is a revision of an earlier version published in January 2007. It takes account of recent developments and changes in the way that single dispensing errors are to be dealt with by the Society and updates the Society's position in relation to the use of medication error logs. The LEB also corrects some of the comments made by Mr Wardle concerning the use of error logs during the course of a Society inspection and makes it clear that on routine pharmacy inspections, Society inspectors do not 'flick through' error logs hoping to use them as 'evidence of misconduct'.

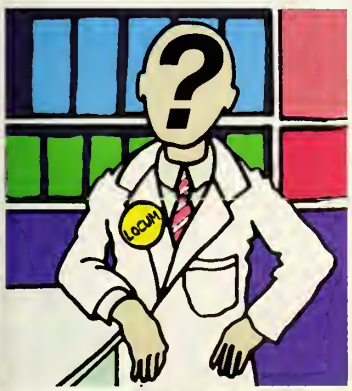
The maintenance of error logs is seen as good practice, and during the course of any investigation undertaken into allegations received by the Society, relating to dispensing errors, the inspector will usually seek to confirm whether or not an error log was maintained at the pharmacy where the error occurred. Confirmation that an error log has been maintained is seen as evidence of good practice and will be reported as such. The maintenance of medication error logs together with the regular audit and review of the errors, with a view to improving systems and procedures within the pharmacy is to be commended.

The Society would be most concerned if pharmacists were discouraged from maintaining medication error logs as not only could this form the basis for an allegation against a pharmacist, but it is also not in the public interest for pharmacists to fail to maintain such logs and take steps to improve systems and procedures when things go wrong.

Jackie Giltrow, chief inspector, Royal Pharmaceutical Society

> "Society inspectors do not 'flick through' error logs hoping to use them as 'evidence of misconduct'"

Locum hits the nail on the head



I could not agree more with the 'Locum at large' column in C+D (June 23, p14). Parts of it could be describing my own working day, and this is only a small shop.

Roll on retirement!

Janet Buxton
NHS Grampian

Do you have a view? Email haveyoursay@cmpmedica.com

Your letters

Pharmacy behind C+D campaign

...e to ...n to keep ...d ephedrine ...one ...by MRPharmS ...ersey

I would like to lend my support to your campaign. Reclassifying ephedrine and pseudoephedrine to POM status would lead to colossal queues at GP surgeries and seriously restrict the public's access to effective medicines. Why should a GP be seen as more trustworthy than a pharmacist? There is no safety issue as regards the use of these medicines for their intended purpose so the only reason I can see for reclassifying is that pharmacists are not trusted to supply them for their appropriate use.

Pharmacists have shown over and over again in the past that they are able to restrict the purchase of drugs of abuse and in the current climate of increased devolved responsibility towards the profession this step is retrograde and superfluous. If a reclassification is needed then supply by pharmacist-issued prescription with the appropriate record-keeping and monitoring seems a much more logical step, but that would be much too much of a progressive step for our allied healthcare professionals to tolerate wouldn't it?

Paul Barry MRPharmS
Cheshire

Knee-jerk responses by government (if in doubt, legislate) over such issues don't work. Remember dangerous dogs, knife and gun amnesties, conifers and right to light etc?

This must surely be the best example ever of where the needs of the huge majority of innocent, legitimate users will be ignored as the authorities ineffectually attempt to frustrate the perceived threat.

Why should we lose the ability to supply long-established and effective remedies to sufferers? Isn't the record of community pharmacy in protecting the public from harm through abuse worth anything?

A ban on OTC packs as a source of crystal meth raw material in the UK is hardly likely to stop the traffic – heroin, cocaine and substances not found in licensed medicinal products still manage to find their way onto our streets.

I appreciate the terrible health consequences that the use of crystal meth brings to its victims – however, our ability to challenge this threat cannot be met by a simple ban on pseudoephedrine-containing medicines.

Tim Burrows MRPharmS

It's unclear why there is a need for a switch. Is there any evidence that ephedrine/pseudoephedrine is being mis-sold? I have not noticed any increase in sales of these products and wonder what the MHRA is trying to achieve.

John Williams
Wales

With reference to the proposed ban on sales of pseudoephedrine from pharmacies due to their being the supposed source in this country of raw material for crystal meth, it would appear the amounts that could be obtained from pharmacy sources as opposed to the internet and illegal supplies would seem woeful for a potential illegal laboratory, not to mention the cost.

Has the MHRA no idea that this is produced within a criminal fraternity and thus most raw materials will be obtained illegally, either by stealing or from the unregulated internet, not by limited purchases of relatively expensive products from pharmacies?

To illustrate this, I have just obtained for disposal in my pharmacy, after careful counselling and some persuasion of the patient, 3 x 100 tablets of ephedrine obtained by a female patient from a Canadian website, which was selling them as a 'legal' and cheap alternative to amphetamines for appetite

Email us your views and comments:
haveyoursay@cmpmedica.com

> "The crafty misusers will not take long to work out a scam to obtain supplies via the GP route"

suppression. The patient had presented with side effects which, after careful questioning revealed the use of ephedrine. There seemed no limit to the number of bottles the patient could purchase, and they apparently were received within days of the order.

Such a situation makes the banning of legitimate pseudoephedrine for self-medication from a controlled source (pharmacies) a farce, and the potential workload on GPs having to prescribe an effective and useful decongestant for colds and other self-limiting conditions is unthinkable.

I hope evidence like this may help the MHRA make a somewhat more rational and logical decision.
David Stolton MRPharmS

I support the Stop the Switch campaign to abandon the MHRA proposals to reclassify pseudoephedrine + ephedrine as POMs.
Calvin Rendle MRPharmS

I too would like to give my support to the campaign to Stop the Switch as pseudoephedrine is such a useful OTC drug that can really help congestion when sold appropriately.

As it can cause problems to patients with BP, diabetes and several medication interactions, our staff already exercise strict protocols when selling products containing pseudoephedrine and these could be further enhanced to prevent multiple purchases and pack sizes could be reduced to three to four days' supply (quite sufficient).

Not only would the switch from P to POM inconvenience the vast majority of the law abiding public and GPs who have better things to do than treat colds, but would it not be a temptation for the doctors to supply more than was strictly necessary as the patient may have to pay £6.85 for the pseudoephedrine preparation or if they were the type that would visit regularly with a cold and a larger quantity could prevent multiple visits.

As a result of possible prescribing of larger quantities there would be a lot more pseudoephedrine in the public domain and the crafty misusers will not take long to work out a scam to obtain supplies via the GP route. I might add that several years ago our local PCT (not called that then) decided to save cash by prescribing paracetamol and codeine separately, until they discovered that a market developed for the codeine tablets and the elderly were approached and were supplementing their pension with the sale of their excess tablets.

In the very old days S1 poisons could be sold to the public if the person was known to the pharmacist and the sale was entered in the poisons register. As pharmacists we have become used to the numerous new regulations so another new category to include a restricted sale of pseudoephedrine and a few others I could suggest could be a better solution than a total ban.
Linda Henderson MRPharmS

As a pharmacist with over 25 years' retail experience I feel very strongly that the switch of ephedrine and pseudoephedrine to POM status not only undermines the drive to enhance the healthcare role of the pharmacist but takes away the only effective drug we have left as a decongestant.

Why can we not police the sales of these items ourselves, ie along the lines of New Zealand, rather than using a 'sledgehammer to crack a nut' approach which will see an extremely useful drug taken away from the millions of people that use it legally due to the few who, the MHRA assumes, are going to stockpile it for manufacture of a class A drug.
V Beal

I have never knowingly sold medicines containing pseudoephedrine that I felt were being abused or being used to manufacture methylamphetamine.
C Tomlinson MRPharmS

Your views

Scottish roadshows prove a great success

Giving local pharmacists a voice shows that we want to listen to their views

Good two-way communication is at the heart of every successful organisation and the Scottish Pharmacy Board is no exception.

Engaging effectively with our members individually and through the branch network is a central objective of the Board and we are determined to deliver this sooner rather than later.

The Scottish Pharmacy Board is proving true to its word. Roadshows entitled A Vision for Scottish Pharmacy – Have Your Say, highlighting the role of the Board and laying open for discussion the challenges and opportunities facing the profession, have been held in five cities across Scotland.

These events stemmed from the Board's recognition that to truly reflect the thinking of the profession we needed to gain a thorough understanding of the expectations and needs of local pharmacists, not only in relation to the Board and the Society but also in terms of their vision for Scottish pharmacy. We are delighted that our first foray into direct communication has been a great success, encouraging attendance and members only too keen to raise a range of topics with us, in particular the future of professional leadership in Scotland.

In this time of change for the Society and the profession it is vital that we keep as many people as possible informed about what is going on and it is even more important that we engage with our membership, allow them to communicate their views, listen and take appropriate action.

The roadshows are not the only communication method being used to bring members more in touch with the workings of the Scottish Board. Plans are underway to make more use of e-communications, with direct contact made with members through email and a refreshed website, as well as the revamped quarterly newsletter.

Without doubt, the Board's main priority is to ensure a modern branch network exists to meet the needs of its members and provide a platform for positive two-way communication.

The branches and the Board acknowledge that times have changed since the system was introduced and it struggles to be sustainable in its current form. We are committed to working together to develop an effective communications network that makes better use of different channels of communication, such as online discussion, and which is genuinely representative. We are also determined to create a framework that supports pharmacists in their day-to-day practice and attracts the involvement of a younger generation.

This is only the start of the process but I'm confident that we've shown already that we're committed to being a Board that knows when to lead and, most importantly, knows when to listen.

Dr Rose Marie Parr
chairman
Scottish Pharmacy Board

C+D Clinical

Shooting the messenger

Antisense technology has the potential to offer medicines that work in radically different ways from conventional drugs

Key points

- Antisense pharmaceuticals work through a radically different mechanism to conventional drugs: short sequences of nucleic acids prevent the instructions encoded in mRNA from reaching the ribosome.
- As antisense pharmaceuticals switch off only certain genes, they may be more effective and better tolerated than less specific conventional agents.
- While they are fundamentally similar, antisense oligonucleotides and siRNA have several chemical and biological differences.
- Numerous antisense technologies are showing promise in clinical studies for a wide variety of diseases.

Mark Greener

Despite modern medicine's chemical, therapeutic and mechanistic diversity, most drugs act by targeting a protein. Beta-blockers and beta$_2$-agonists bind to receptors. ACE inhibitors and Cox-2 inhibitors block enzymes, while anticonvulsants and calcium channel blockers influence the movement of ions through protein channels in the cell membrane. However, a new generation of 'antisense' pharmaceuticals works through a radically different mechanism, by switching off certain genes. Indeed, one recent review commented that "it is hard to imagine a class of synthetic compounds more dissimilar from traditional drugs".[1]

This article introduces this innovative approach to treating diseases as diverse as cytomegalovirus retinitis, dyslipidaemia, HIV and certain cancers.

A novel mechanism

DNA consists of four nucleotides: adenine, thymine, cytosine and guanine. Nucleotides on one side of DNA's double helix bind to their complementary partner on the other side, eg adenine to thymine and cytosine to guanine, in a pattern. Biologists call this pattern 'Watson-Crick hybridisation'. When

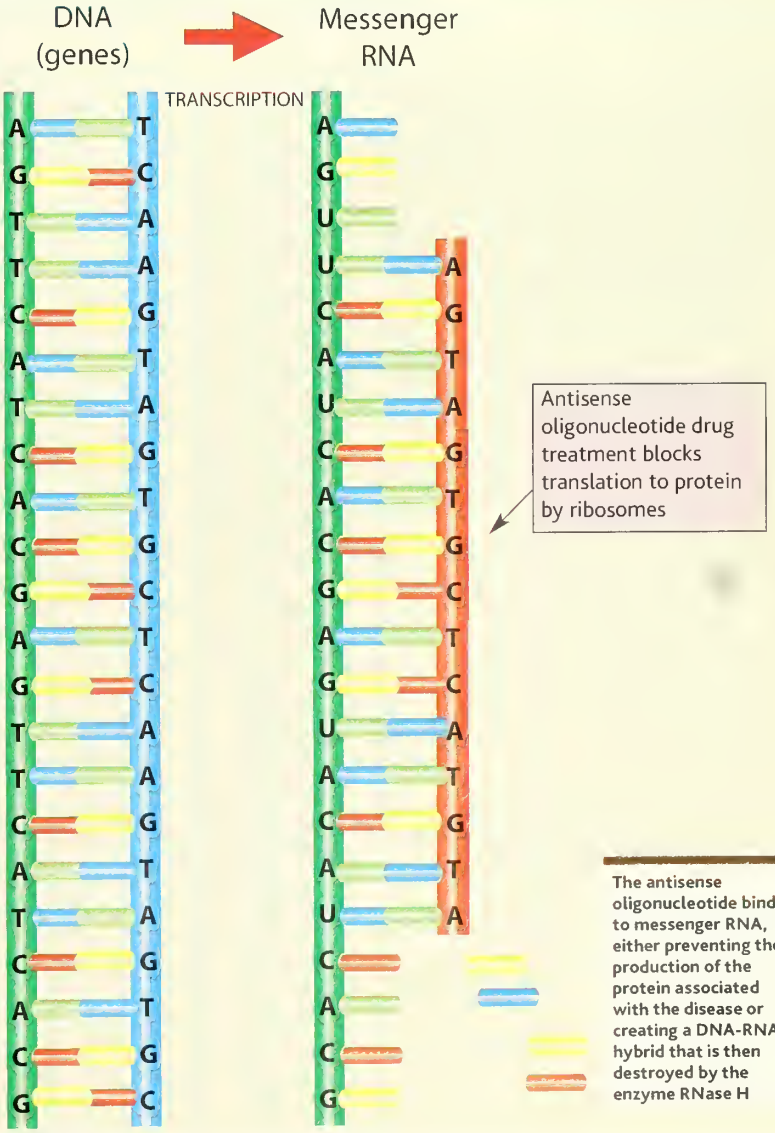
Reflect

What do you know about antisense technology? Antisense pharmaceuticals differ markedly from conventional drugs – do you know their potential benefits and applications?

Plan

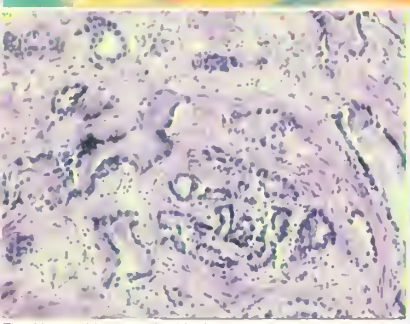
This article focuses on the main antisense technologies – oligonucleotides and small interfering RNA – and outlines their therapeutic potential.

CPD This article can help in the following CPD competencies: G1a, G8a, G8b. See www.tinyurl.com/194zu

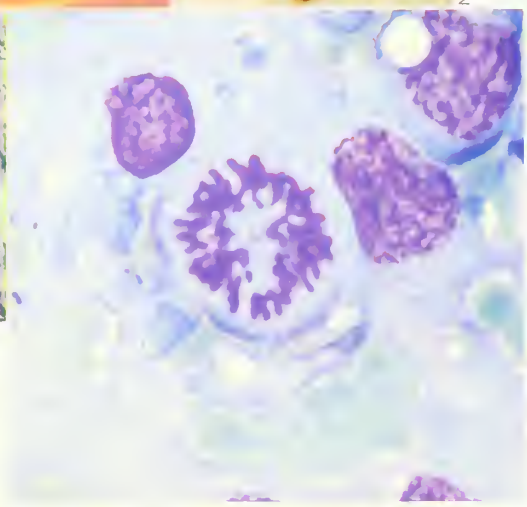


The antisense oligonucleotide binds to messenger RNA, either preventing the production of the protein associated with the disease or creating a DNA-RNA hybrid that is then destroyed by the enzyme RNase H

National Cancer Institute



The National Institute for Health



Ed Uthman, MD

Clockwise from top left: age-related macular degeneration, melanoma on a patient's skin, mytosis in a lymphoma cell and prostate adenocarcinoma are all potential early targets for antisense treatments

the cell requires the protein encoded by the gene, an enzyme called RNA polymerase transcribes the genes into RNA. This usually creates a nucleotide sequence that is complementary to the DNA. This messenger RNA (mRNA) moves out of the nucleus, and organelles in the cytoplasm (ribosomes) build the proteins based on the instructions in the mRNA.

Antisense technology uses short sequences of nucleic acids to prevent the instructions in mRNA from reaching the ribosome.

This article focuses on the two main antisense technologies – oligonucleotides and small interfering RNA (siRNAs) – although others are in development.

While these antisense approaches differ in the details of their mechanism of action, they all selectively recognise specific molecular targets and pathways. As antisense pharmaceuticals switch off only certain genes, they may be more effective and better tolerated than less specific conventional agents.[2]

Antisense oligonucleotides

First developed in 1978, antisense oligonucleotides contain between 18 and 25 deoxynucleotides (those in DNA) complementary to those in the target mRNA.[3] They can be used to selectively inhibit production of one protein,[2] such as an enzyme or receptor.

Once bound through Watson-Crick hybridisation, some antisense oligonucleotides block protein production by physically obstructing the ribosome. Others form an RNA-DNA hybrid. This acts as a substrate for the enzyme RNase H, which destroys the mRNA.[1]

The length of the oligonucleotide seems critical. Very short sequences usually lack specificity, while cells may not be able to uptake sequences containing more than 25 nucleotides.[2] Chemical modifications to the nucleotide sequence boost efficacy and stability. For example, several new antisense oligonucleotides are 'gapmers' that consist of a central DNA portion, which recruits RNase H, flanked by regions that resist enzymatic degradation and increase the nucleotide's affinity for its target. Chemical modifications to the nucleotide backbone can also increase resistance to degradation and improve distribution pharmacokinetics.[1]

Small interfering RNA

In 1999, British researchers found that plants produce small antisense RNA when, for example, infected with RNA viruses.[4] These siRNAs probably evolved to protect cells from viral attacks and the detrimental effects of 'jumping genes' or transposons – segments of DNA that can move around the genome.[3]

Because they are present in large amounts, transposons can join areas of the genome that are usually non-contiguous. In some cases, this causes a gene to be deleted or duplicated. Some deletions or duplications increase the risk of cancer and other genetic problems. For instance, the human genome contains around a million copies of one transposon – called alu – which is responsible for one in every 333 human genetic diseases. Indeed, 45 per cent of the genome may be potentially transposable, although relatively little is active, and more than 500 genes contain transposable elements.

While it seems transposons facilitated evolution, they are also potentially hazardous and siRNAs offer one line of defence.[5]

siRNA belongs to a large family of small RNAs (microRNAs), which do not code for proteins but control the activity of other genes, often by modulating mRNA function. As such, microRNAs influence the development of numerous critical organs, including the brain, lung, spleen and heart. They also control normal physiological processes, such as modulating blood cell production from haematopoietic stem cells, adipocyte differentiation and insulin secretion.[6]

As a final example, microRNAs seem to regulate chromosome dynamics and modify chromatin. Chromatin, a combination of DNA and protein, has various roles including stabilising the double helix, controlling gene expression and modulating chromosome replication.[6]

Given their role in normal development and central physiological processes, it is perhaps not surprising that dysfunctional microRNAs also contribute to numerous diseases, including the oncogenesis underlying Burkitt lymphoma, colorectal cancer and lung cancer among others.[6]

While they are fundamentally similar, antisense oligonucleotides and siRNA have several chemical and biological differences. For example, cells express a cluster of proteins called the RNA-induced silencing complex (RISC), which recognises siRNA and aids its pairing with its target mRNA. Unlike siRNA, however, cells do not express a mechanism that promotes antisense strand recognition and instead rely on chance encounters.[1] Furthermore, siRNA may offer some other advantages over antisense oligonucleotides, including a high degree of specificity to the mRNA, a lower risk of triggering immune reactions and greater resistance to enzymatic destruction.[3]

Antisense oligonucleotides have some advantages, however, including their low molecular weight; they are also less likely to disrupt normal physiology than siRNAs, which have essential biological roles.[1]

Therapeutic potential

Antisense technology rapidly emerged as a powerful tool for biologists; being able to switch a specific gene offers a powerful tool to unravel a protein's function in a complex cellular system and offers new insights that aid drug development. For the last 20 years, therefore, researchers have tried to employ antisense technology directly to treat various diseases, but poor intracellular delivery, problems with the oligonucleotide's stability, toxicity and difficulty accessing the target

A proposal

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mRNA have slowed the introduction of oligonucleotides into the clinic.[7]

Nevertheless, the US Food and Drug Administration (FDA) approved the antisense oligonucleotide fomivirsen, administered by intraocular injection for cytomegalovirus retinitis. Indeed, several groups are exploring the potential of antisense technology in other ocular disorders. The eye is an attractive initial target partly because small amounts of material are needed, making treatment less expensive, and partly because the innate eye's defence and clearance mechanisms promote cellular uptake of siRNA. A variety of clinical studies are assessing siRNAs targeting vascular endothelial growth factor (VEGF) in age-related macular degeneration[3] and, if successful, these should enter clinical practice over the next few years.

Numerous antisense technologies are showing promise in clinical studies including oligonucleotides targeting the protein tyrosine phosphatase 1B (which helps regulate the action of the insulin receptor) for potential use in type 2 diabetes, and apolipoprotein B for dyslipidaemia. The next few years will also probably see antisense technology established as treatments for various malignancies including prostate cancer and B-cell lymphoma. For example, oblimersen sodium targets Bcl-2, a protein that seems to induce resistance to chemotherapy by countering apoptosis (programmed cell death). Oblimersen sodium is currently in late development (phase III or regulatory approval) for advanced melanoma and chronic lymphocytic leukaemia (CLL).[8]

Other applications in earlier stages of development include targeting the protein tyrosine phosphatase 1B (which helps regulate the action of the insulin receptor) for potential use in type 2 diabetes and interfering with the gene for apolipoprotein B to treat dyslipidaemia. Other researchers are looking into multiple sclerosis, neurodegenerative diseases and various infections.[1,3]

Indeed, siRNA and other RNA interference technology seem to be effective in vitro against several RNA viruses (such as HIV, influenza, hepatitis C and respiratory syncytial virus) as well as some DNA viruses, including human papilloma virus, hepatitis B and herpes simplex.[3] A recent research project studied oligonucleotides chemically modified to increase their stability and affinity for mRNA (called locked nucleic acids) that prevent the reverse transcription of viral RNA into DNA.

Oligonucleotides using locked nucleic acids emerged as highly potent inhibitors of HIV-1 expression in cell culture. They were much more effective than conventional DNA sequences against the same target and may offer a new antiviral treatment against AIDS.[7]

It will still be several years before many of these agents reach the market, although clinical studies are promising. There are many other possible clinical applications for siRNA and other RNA interference technology, researchers need to overcome several hurdles, such as distributing the nucleotide to the site of disease, before they can realise the full potential offered by antisense technology. Nevertheless, it is clear that this approach represents a radically new way of treating disease and the therapeutic applications will undoubtedly expand rapidly over the next few years. Antisense technology shows that, sometimes, it's a good idea to shoot the messenger.

References are available at www.dotpharmacy.com/advances

Websites

- The RNAi Information Portal – www.rnai.net
- RNA Interference Research – www.si-rna.com
- RNAi News – www.rnainews.com
- RNAi Web – www.rnaiweb.com
- Nature collection – www.nature.com/focus/rnai/index.html

Continuing Professional Development CPD

Act

- Revise your knowledge of basic genetics. An article in C+D (Unlocking the secrets of DNA, March 29, 2003, p19-20) outlined the therapeutic implications of recent advances in genomics.
- Look at websites recommended by the author of this article. Websites of the British Society for Gene Therapy, The Human Genome Project and the UK Cystic Fibrosis Gene Therapy Consortium are other sources of information. The ISIS Pharmaceuticals site (www.isispharm.com) gives an industry view.
- One of the most attractive attributes of antisense is its specificity, but can you think of any disadvantages? Visit www.dti.gov.sci/science to look at government thinking on the potential for misuse of DNA sequences (oligonucleotides).

Evaluate

Do you know enough about antisense technology, bearing in mind that aside from eye treatments it may be some time before many therapeutic agents based on this technology reach the market?

Be part of the next step for C+D's clinical coverage

The editor and staff of C+D are always searching for new ways to make the journal's content relevant and useful to its readers.

To that end, we invite you to fill out a short online questionnaire designed to allow you to explain what you like and don't like about C+D's clinical content, including the clinical news section, the Pharmacy Update articles and their associated CPD element.

To make the whole thing more interesting, we're offering a £100 prize draw. One lucky pharmacist reader who completes the questionnaire will win £100.
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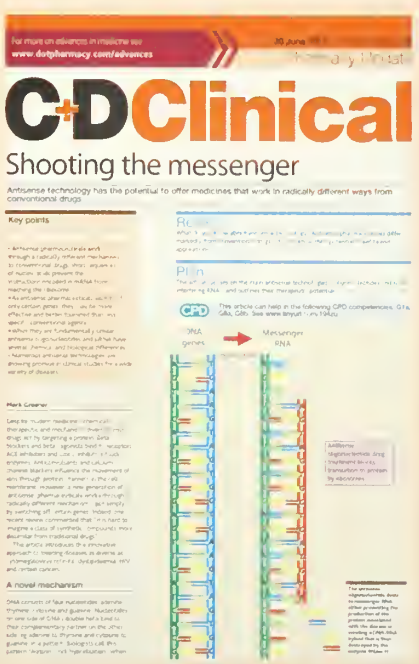

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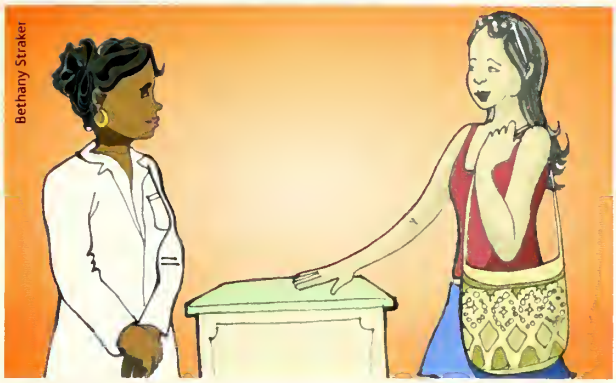
C+D News bulletin

Clinical News

A Practical Approach...



Claudine, medicines counter assistant at the Update Pharmacy, sees her friend Sandra come in with a prescription.

"I've had another bout of cystitis, so I thought I'd see the doctor," says Sandra. "He doesn't think there's much wrong, but it might be an infection so he's prescribed some antibiotics, and said that if I get any more attacks he will investigate."

"You're looking cheerful for someone not feeling too good," Claudine says.

"I am feeling cheerful! I think I might be pregnant. We've been trying for ages. I haven't said anything to Brian yet, and I thought I'd get a pregnancy testing kit while I'm here and tell him once I'm sure."

"Would you mind me mentioning to Mr Spencer that you might be pregnant? He's always saying we should ask women if they are when they come in to buy medicines over the counter."

"Sure, that's OK."

"And are you taking any other medicines at the moment?" "Yes, you know I've been taking those folic acid tablets that you're supposed to if you're planning on having a baby."

"Thanks," says Claudine, and takes the prescription for trimethoprim 200mg tablets into the dispensary.

Questions

1. Could there be a problem with this prescription? If so, what?
2. Would the fact that Sandra is taking folic acid be of relevance?
3. What action should be taken in this situation? Answers below.

CPD This article can help in the following CPD competencies: G1a, G1c, C1a, C1b, C1f. See www.tinyurl.com/194zu

A Practical Approach... this week's answers

1. Trimethoprim is a dihydrofolate reductase inhibitor, inhibiting the conversion of bacterial dihydrofolic acid to tetrahydrofolic acid, which is necessary for bacterial DNA synthesis. Folate is also necessary for human cell synthesis, and needs are greater during pregnancy. Extra intake of folic acid is recommended during the periconceptional period to protect against congenital malformations. Trimethoprim, by depressing folate synthesis, can have teratogenic effects and it has been associated with birth defects, including neural tube and cardiovascular defects and cleft palate. Its use should therefore be avoided in the first trimester of pregnancy. A possible alternative, if an antibiotic is considered essential, is amoxicillin.
2. Sandra's intake of extra folic acid may provide protection against the teratogenic effect, but trimethoprim should still not be used without a compelling reason.
3. David Spencer should inform Sandra's GP, with her permission, that she might be pregnant. The GP might decide not to prescribe an antibiotic and just recommend symptomatic treatment.

Echinacea may be effective, says study

A meta-analysis has suggested echinacea may be effective in preventing and treating colds, despite previous contrary evidence.

Published in the Lancet Infectious Disease, the US study examined 14 studies covering some 1,356 study participants used to study echinacea's effects on the incidence of cold symptoms, and 1,630 subjects to measure its effects on the duration of cold symptoms.

Patients taking echinacea treatments were 58 per cent less likely to have cold symptoms, and the duration of cold was reduced by 1.4 days on average.

This follows a previous single study published in the New England Journal of Medicine two years ago, which included 437 volunteers and found echinacea treatments used made no detectable difference.

Treatment launched for hepatitis B

Novartis Pharmaceuticals has launched a treatments for hepatitis B. Telbivudine (Sebivo) is licensed for the treatment of chronic hepatitis B in adults with compensated liver disease, evidence of viral replication, persistent elevation of alanine aminotrasferase and histological evidence of acute inflammation or fibrosis.

In brief

EMEA has announced an agreed action plan to follow-up patients who have been exposed to contaminated nelfinavir (Viracept). The treatment for HIV-1 infected patients was withdrawn earlier this month after some batches were found to be contaminated with ethyl mesilate. www.emea.europa.eu

A study published in the Lancet suggests that antihypertensive regimens including the angiotensin-2 blocker valsartan may not be superior to established hypertension treatments in controlling damage to the heart. The authors concluded that effective antihypertensive therapy improves diastolic function irrespective of drug regimen used.

Data presented at the American Diabetes Association Annual Scientific Sessions has added to evidence that sitagliptin (Januvia) in combination with metformin provides a significant reduction in blood glucose levels. The results have also shown a low incidence of hypoglycaemia and low risk of weight gain.

A Lancet review of treatments available for hot flushes has concluded that non-hormonal treatments need to be tested carefully because there is a placebo effect of up to 50 per cent in this area. Also, it suggests centrally-acting agents should be used sequentially rather than in combination.

Brochlor is new sight for sore eyes

Sufferers of acute bacterial conjunctivitis now have another treatment option. Joining Brolene on the OTC fixtures, Brochlor Ointment (1% chloramphenicol) has switched POM to P.

Brochlor Ointment does not need refrigerating, is ideal for night time use, and may prove a preferred format by the elderly and for children, according to a company spokesman. The launch is being backed by advertising, PR and pharmacy training and POS materials.

Product info:
sanofi-aventis
01483 505515
www.aventis.co.uk
Price: £4.95/4g
Pip code: 327-3562

Hospital hygiene at home

HiBiScrub has been launched by Mölnlycke Healthcare, said to be the UK's first chlorhexidine-based bodywash. The GSL product is designed to be used by people prior to and during a stay in hospital.

Containing 4 per cent chlorhexidine gluconate, HiBiScrub is 99 per cent effective against bacteria, common fungi and certain viruses with repeated use, claims Mölnlycke. It remains effective for up to six hours.

The product has been widely used within the NHS for scrubbing up for around 40 years. With the growing problem of MRSA, Mölnlycke feels there is a need for the product to be made available in the community.

There is a lack of consistent information for patients about to go into hospital, says the company's international business development manager Steve Evans. To rectify this, consumer education is underway with a poster and leaflets in GP surgeries, a website and shopping centre roadshows beginning in October. Mr Evans recommends positioning the product within first aid.

Product info:
Mölnlycke Healthcare
Tel: 0161 777 2688
www.hibihelath.com
Price: £7.99/250ml

Fibre added to VMS category

Benefiber has been launched by Novartis, said to create a new digestive health category within the VMS market. Containing wheat dextrin, the product is soluble, taste free and colourless. It can be mixed with hot and non-carbonated cold drinks, soups and other foods without changing the texture, says Novartis.

The recommended dosage of two teaspoons delivers 3.5g of fibre to contribute towards the recommended fibre intake of 18g each day. The average adult is believed to consume 12g fibre each day. Benefiber should be taken twice daily.

Supporting the launch, national TV advertising, sampling, in-store promotions and PR activity are planned.

Product info:
Novartis Consumer Healthcare
Tel: 01403 210211
Prices and Pip codes: £2.99/7 sachets, 328-6978; £5.99/38g, 328-6986; £8.99/62g, 328-6960

Sugar-free salivation

Saliva natura has been launched by Medac UK. The sugar-free mouth spray is designed to relieve the symptoms of dry mouth. It has a lemon and lime flavour and is said to give relief for up to two hours.

The spray contains extracts of the yerba santa plant, which mimic the action of saliva. It is suitable for vegetarians and has not been tested on animals. Clinical tests have shown its usefulness in relieving dry mouth conditions associated with pharmaceutical treatments, medical disorders and advancing age.

Product info:
Medac UK
Tel: 01786 458086
Prices and Pip codes:
£4.95/50ml, 325-6302;
£14.95/250ml, 329-3313

New foundations for Macleans

Oralcare brand Macleans is being relaunched with a "strong foundation for healthy teeth" proposition. New pack designs featuring a new logo have been created and a Macleans Total Health franchise introduced.

The brand is expected to appeal to women with a positive attitude to life wanting to do the best for their teeth, roots and gums, says GSK.

Key variants are Macleans Total Health containing zinc and Total Health Whitening. These will be the main focus for the "heavyweight" marketing package supporting the relaunch. This will include television advertising. Completing the line-up are Whitening, Ice Whitening Gel, White & Shine and Fresh Mint. Further product developments are in the pipeline, adds GSK.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 01692 650780
Prices: £1.29/50ml, £1.99/100ml
Pip codes: Total Health 50ml 328-9949, 100ml, 328-9956; TH Whitening 50ml 328-9964

Learning at a distance

New distance learning modules for pharmacists and assistants are being developed by GlaxoSmithKline Consumer Healthcare. The first module focuses on smoking cessation and its launch has been timed to coincide with next week's change in smoking legislation in England.

CPD is central to the new modules says the company. Once completed successfully, personalised certificates record achievement. Mentoring tips are offered to enhance knowledge.

The initiative is part of GSK's "Ask Your Pharmacist First" campaign.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0800 783 3927
www.mypharmassist.co.uk

Vagisil's back

Feminine care range Vagisil is back on TV for the second time this year. The campaign, part of a £1.25 million marketing spend on the brand this year, runs until late August.

Two new ads will be seen. One features Vagisil Medicated Crème, an anaesthetic cream for relief from itching, burning and irritation including thrush. Vagisil Feminine Wash stars in the second, an intimate soap-free, pH balanced cleanser that freshens and deodorises.

More information from Combe International, tel 020 8680 2711.

Products advertised on TV next week

Bepanthen: All areas
Buscopan: GMTV
Canesten: All areas
DulcoEase: five, GMTV, Sat
Frontline: GMTV, Sat, five
Nicorette: All areas except Channel Islands and GMTV
Odor-Eaters: All areas
Rennie Dual Action: All areas
Vagisil: All areas
Wartner: G,Y,C,M,LWT, GMTV, Sat
PharmaSite for next week: Anadin Ultra Double Strength – Windows, **Anadin Ultra Double Strength –** In-store, **Allergan –** Dispensary
Pharmacy channel: Piriton, Eurax

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ADDRESS:.....

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POST CODE:.....

TELEPHONE NUMBER:.....

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Eurax

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Allergic Rash

Q A customer has an angry, itchy rash on his hands and lower arms following a spell of gardening. He has started taking antihistamine tablets and the rash is subsiding but the skin is still very uncomfortable.

A This is probably an allergic rash.
- The antihistamines are just beginning to halt the allergic reaction
- Putting something on to the affected area immediately will help stop the itching and soothe the skin
- Stopping the itch will also help to reduce the likelihood of the skin becoming more inflamed or broken which could lead to infection

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- **S** Stop the itch
- **S** Soothe the discomfort
- **S** Sustain the effect
- **H** Hydrate the skin

Why Eurax

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- Offering up to 10 hours relief
- Tried and trusted – No 1 product in the anti-itch market
  IRI HBA All Outlets
  52 w/e 24 March 2007
- Pleasant to use and easily absorbed

Crotamiton 10%

Eurax can relieve a wide range of skin conditions including itchy dermatitis, dry eczema, allergic rashes, nettle rash, sunburn, heat rash and personal itching.

Legal category: GSL.
For more information contact the PL holder: Novartis Consumer Health, Horsham, RH12 5AB

Find out what the latest generics price changes mean for you with C+D's Category M Barometer

Getting the measure of category M

Since April 2005, pharmacists have wrestled with many elements of the new contract in England and Wales, not least the fluctuating prices of generic products within category M of the Drug Tariff.

For the government, category M provides a mechanism to remove £600 million from purchase profits every year. In an ideal world, category M would remove this £600m in four quarterly chunks of £150m, but in reality there are huge variations between each quarterly category M listing. And with the reimbursement prices for more than 500 medicines subject to unexpected change, pharmacists must make a quick assessment in order to maintain their purchase profits.

To help you get to grips with the impact of the changes made to category M, C+D has teamed up with Actavis to bring you the Category M Barometer.

In true swingometer style, every three months Actavis will calculate the volume weighted prices of the range of generic products in category M from the latest figures issued by the Department of Health. This generates an index of prices which, using the products in the first category M as a baseline, shows how the figures have changed since the scheme's inception in April 2005.

The quarterly change to this index figure will generate a barometer reading. This provides a snapshot of the overall reimbursement level for the quarter to indicate how much better or worse off you are as a result of the changes. Ultimately, it will show you whether the government is taking more or less money out of your purchase profits.

We will also highlight which generics are up, which ones are down and our resident pharmaceutical statistician – Generic Eric – will explain how those changes impact on your day to day business.

The variations in the quarterly reimbursement levels identified by the barometer reveal how the DH controls its quarterly spend. This task is not always easy. Unlike our calculations, which use historic annualised market volumes, the DH has to budget for projected volumes. It does, however, indicate that where reimbursement levels are low in a quarter, subsequent tariff levels have provided higher levels of reimbursement. For pharmacy this ensures there is a smoothing effect over the year and maintains purchase profit at agreed levels.

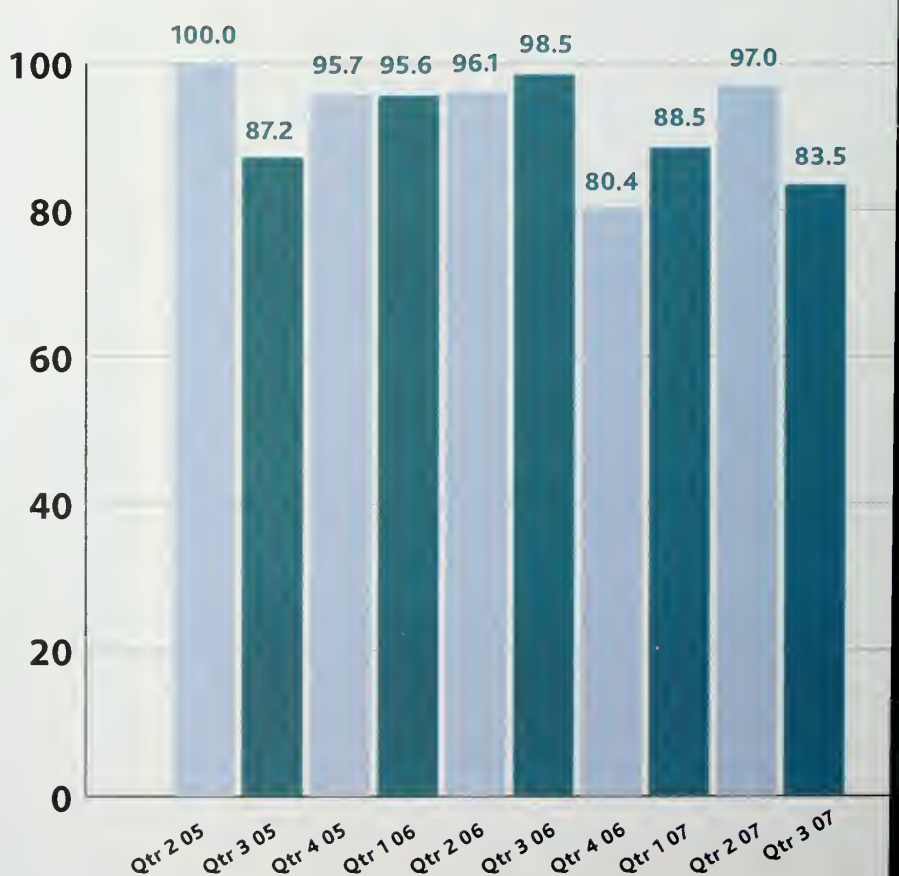
> "Pharmacists must make a quick assessment to maintain purchase profits"

Category M two years on

Since the second quarter in 2005, the overall reimbursement level has returned to historic levels. However, during this period a number of products have come off patent, including lamotrigine, fosinopril, terbinafine, lansoprazole, sertraline, glimipiride, tamsulosin, sumatriptan and ondansetron. The department has, therefore, got more product for the same overall budgetary spend, although not all of these products reside in category M.

The following shows how the reimbursement levels have varied over the period since the introduction of category M, taking account of these off patent additions

How reimbursement levels have varied since the launch of category M in the second quarter of 2005



Category M – a reminder of how it's done

- Information on volumes and prices of sold products is gathered from manufacturers
- Information on dispensing volumes is gathered from the NHS BSA Prescription Pricing Division
- Supply chain margins are calculated
- Following negotiations with PSNC, prices are adjusted based on estimated volumes
- PSNC monitors the changes through feedback meetings with the DH
- Any over or under recovery is accounted for in the next quarter

For more on the Drug Tariff changes go to:
www.dotpharmacy.com/categorym

-14%
July-September 2007

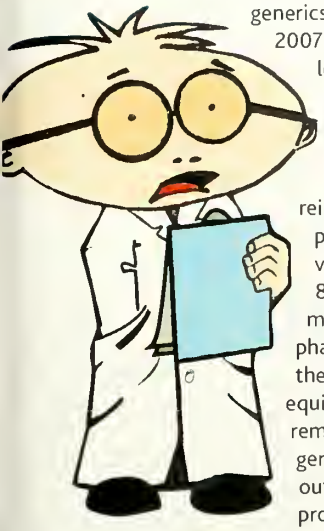
Need advice on category M?
Email your question to:
categorym@cmpmedica.com

Quarter 3 2007

The last two quarters have been kind to pharmacy, with the Barometer moving from 80.4 in quarter four 2006 to 88.5 in quarter one 2007 and then up to 97.0 in the last quarter. However, the graph opposite shows that it has slipped back to 83.5 this quarter.

The graph shows how with the introduction of the new category M, the originally reduced value of the tariff has been increased with the off patents that have been introduced at the various timeslots.

Generic Eric explains the latest category M changes:



"While the overall reimbursement level of generics products in quarter two 2007 was similar to 2006 levels, the Barometer indicates a significant change with the release of the latest figures. The overall reimbursement dropped 14 per cent in annualised volume terms from 97.0 to 83.5. This will have a material impact on pharmacy purchase profit in the quarter. It is the equivalent of £220m being removed from the tariff on generics through the year outside the negotiating process with PSNC. To put it another way, it breaks down as £17,600 per pharmacy per year or around £1,500 per pharmacy per month.

While this is a statistical analysis and for one quarter only, it is clearly a radical tariff for retail pharmacy. We can only assume that the Department has underrecovered against its budget but it would be interesting to find out more from the bodies involved.

The exact nature of this loss of revenue will depend on the dispensing profile of the pharmacist and the types of products commonly used. However, early indications are that some market prices may be above the tariff and this could result in individual product losses for the pharmacist eg phenytoin and gabapentin 400mg.

It will be interesting to see how manufacturers and distributors react to this in their July price lists. Pharmacists should protect themselves by ensuring discounts are guaranteed in relation to the volume of their purchases. That will take products below the tariff, protecting elements of purchase profit while ensuring that they take advantage of all the funding available for provision of services.

Discount schemes have their pros and cons but some schemes ensure discounts start on all purchases and others tend to reward high volume usage. Pharmacists should choose a scheme that is right for them. This removes some of the risks associated with a tariff such as this and will provide some insurance for the independent.

The other big issue is timing. With payments by the PPD taking up to three months, the tariff reductions will have a knock on effect at the end of the year – a time when pharmacists are carrying additional stock for the festive period, staff costs are higher and the pressure on pharmacist cashflow is most acute. This will hit both large multiples and independent pharmacists alike."

For more details on this quarter's category M changes including the full list of reimbursement prices visit **www.dotpharmacy.com/categorym**

What's hot

Product	pack size	April 2007 tariff	July 2007 tariff	changes	% changes
Ketoprofen 50mg capsules	28	£6.45	£7.88	+£1.43	22%
Nizatidine 300mg capsules	30	£6.73	£7.02	+£0.29	4%
Hydralazine 25mg tablets	56	£6.13	£6.21	+£0.08	1%
Methyldopa 125mg tablets	56	£5.61	£5.64	+£0.03	1%
Ofloxacin 400mg tablets	5	£6.16	£6.17	+£0.01	0%

Data and analysis supplied by Actavis

Only four lines managed a rise this quarter with the rest of the entire category M portfolio either static or in decline. This cannot be reflective of a market as complex as the generics market and does not take into consideration the products where market prices have been rising this year. Ketoprofen 50mg has had a stellar rise and would appear to be a significant anomaly of this tariff whereas the slight tariff rise for hydralazine 25mg could have been expected as the market price has been rising this year given some supply difficulties from manufacturers.

What's not

Product	pack size	April 2007 tariff	July 2007 tariff	changes	% changes
Disopyramide 150mg capsules	84	£48.60	£32.86	-£15.74	-32%
Gabapentin 400mg capsules	100	£26.96	£18.77	-£8.19	-30%
Lamotrigine 200mg tablets	56	£27.53	£19.30	-£8.23	-30%
Hydrocortisone 1% cream	50g	£20.76	£14.63	-£6.13	-30%
Sertraline 100mg tablets	28	£2.05	£1.50	-£0.55	-27%

Data and analysis supplied by Actavis

The table shows the extent of the reduction in reimbursement process across the board but there are some notable exceptions in this list which are not considered where market prices have been rising and market price may be above tariff eg gabapentin. Such volatile changes take stability away from the market and pharmacists have to shop around on these lines to ensure purchase profit is maximised. Falls in products such as lamotrigine could have been predicted given the decline in market price over the previous few months.

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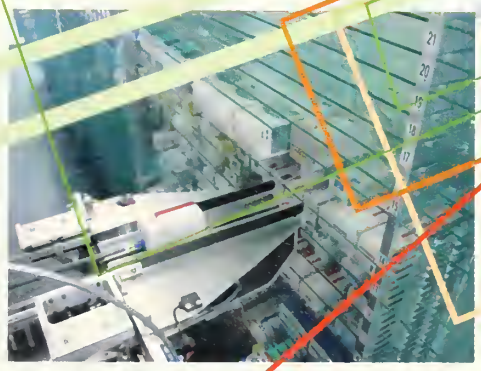
The rise of the machines



Automation has been heralded as the future of dispensing, but has UK community pharmacy welcomed robots into the fold with open arms? Tom Hawkins investigates

When automated dispensing systems emerged onto the UK community pharmacy market they were greeted with a cautious welcome and quickly divided opinion: expensive replacement for valuable staff or the vehicle for an efficient pharmacy?

Both the technology and the market have moved on since then, but the fact remains: automated dispensing machines, or robots, have been embraced in much greater numbers by the profession's contemporaries on the continent than in the UK.

Tony Hubbert, UK director of pharmacy automation manufacturer RoboPharma, explains: "It's still looked upon as new. There's an increasing acceptance that it is a good development and provides an 'in control' pharmacy but it's still in its infancy."

But as workloads mount, automation has become an increasingly tempting proposition to maintain profitability, particularly compared with the alternatives of getting a bigger store, opening longer hours or employing more staff. If a pharmacy team is struggling over the peaks and troughs of daily demand, then a robot is the equivalent of a Land Rover effortlessly smoothing the terrain.

Raj Nutan, pharmacy business manager at the NPA, explains: "Time is critical going forward. Pharmacists are still seeing a yearly increase in scripts of 6 to 7 per cent but they are being paid less for volume and more for service. Robotics provides a plug in that gap when it frees up time for pharmacies which are still doing volumes."

One pharmacist who has seen the benefits of employing technology is George Romanes of Romanes Pharmacy in the Scottish Borders. He has been running a Willach Consis automated dispenser since February. "It's certainly speeded up the workflow for acutes and we can make better use of NVQ4 technicians," he says. "Instead of trying to get half a technician, the robot's done that work. What it's done is replaced time."

WA Salters pharmacy in St Helens operates a ROWA Speedcase system from ARX. Pharmacist Mohammed Ashraf says that as well as saving time the fact that stock is automatically entered into the machine reduces the risk of human error.

He says: "It definitely improves accuracy. Every item is scanned on so the amount of errors is significantly reduced."

Mr Hubbert says rather than feeling threatened by the increasing use of automation, such applications can have a positive impact on the staff. "They're getting through an increasing script count and they're not shattered mentally and physically. It nicely arrives at their side so they're more in control and less stressed as a result."

Remote control

He says the company is continually developing its automation technology and exploring new applications. In Holland, one pharmacist has been given permission to dispense remotely using the company's RoboRemote platform.

Although this could not happen in the UK at present, Mr Hubbert believes this will be a conversation that will be taken up with the Royal Pharmaceutical Society in the near future.

"I don't think we'll have it [the conversation]. Our customers will have it. It needs one of the big players to go forward with it. From our point of view it's ready to go."

ARX, a value added distributor for automated dispensing equipment, is also exploring remote applications with its Visavia product. Dave Harper, community sales manager, says: "You can be sat at home dispensing while the machine's picking, labelling and delivering to an 'ATM' terminal with audio/visual feed."

Mr Harper says Visavia does not provide a replacement for a pharmacist but could be a

solutions for out-of-hours support, only for consultations. The success of the product, though, is reliant on strong, secure links to PMR systems.

"If used ethically, it's fantastic for the market for offering services where they're not available currently," says Mr Harper.

But the question of ethics remains and it is one of which the Society is well aware. Lynsey Cleland, head of professional ethics, says: "It is essential changes to legislative requirements and advances in technology enable pharmacists and pharmacy staff to make the best use of their skills and expertise without compromising patient safety."

To buy or not to buy

The argument for investment in a robot is made stronger if pharmacies can predict demand, since it can cover the top 20 per cent of products that make up 80 per cent of the workload. As Nice guidelines and PCT formularies increasingly dictate prescribing habits, this is evermore the case.

Deciding on what robot to go for depends on a multitude of factors, such as space and budget. Mr Nutan of the NPA says the relatively high initial outlay means a robot is likely to be a long term investment as part of a five, seven or 10-year business plan rather than a quick fix. It is equally important to put in place robust contingency plans in the event of glitches and down time. "You need a strong internal business case," he says. "Look at your fixed and variable costs and installation costs."

Lloydspharmacy is one company weighing up the technology. It has installed automated dispensers from both ARX and RoboPharma to investigate the business case. Andy Murdock, pharmacy director at Lloydspharmacy, says early indications from the systems are encouraging but that it is too early to make a judgement on whether the technology will enable the company to expand the range of services it offers.

He says: "If robotic technology is cost effective in helping to free up pharmacists' time then we will consider how we can best deploy it, but right now it's too early to say."

If companies such as Lloydspharmacy do embrace automation it could be influential in making robots a more accepted part of the UK pharmacy landscape.

Mr Harper of ARX concludes: "Over the next year it will become more normal. If someone's looking at a shopfit they'll certainly be considering it – it's just in what guise."

Case study

Sherman Pharmacy in Canning Town, London, went live this month with an automated dispensing system from ARX as part of a complete shop fit.

Director Hament Chavda, who runs the business with Bharat Pandya, says it is part of a wider plan to spend more time with patients and expand the pharmacy's service offering.

"We needed it to have a consultation room and we were thinking ahead because of the new contract."

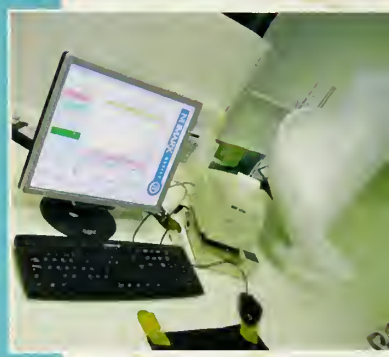
After visiting other automated pharmacies, the partners opted for the ROWA Speedcase system from ARX. Each box is scanned and loaded into the robot via a hopper. The hardware is linked to the RX Systems PMR. Mr Chavda also requested the integrated MAX 2 unit, which stores up to 1,000 items and can deliver multiple packs in seconds.

Mr Chavda says support from Numark Assist proved invaluable to push the project through to completion. He also praised shop fitters Faux Conduit, which had vital experience of robot installations.

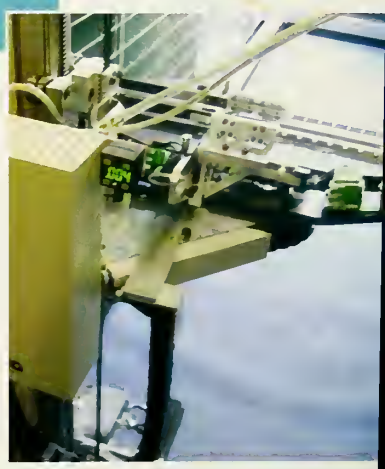
The pharmacy maintained a service to customers throughout the installation, with Numark's merchandising team and Phoenix easing the pressure on stock holding.

Ultimately Mr Chavda hopes the efficiency gains will enable staff to spend more time delivering MURs, smoking cessation and substance misuse services, EHC and a minor ailment scheme. Sherman Pharmacy is also targeting new service provision in chlamydia testing, diagnostic testing and weight management.

"We're now achieving what we set out to do and that's service provision."



Hament Chavda (top), director of Sherman Pharmacy, plans to expand his service offering after installing a dispensing robot from ARX as part of complete shop fit. Items are picked from the cabinet (bottom) and delivered via a twisting chute directly to the PMR terminal (above)



> "Put in place robust contingency plans in the event of glitches"

Would you like a dispensing robot in your pharmacy?

Eighteen months ago we asked C+D readers whether they would like to have a robot in their pharmacy. To gauge how views have changed we repeated the same poll last month.

The results (see diagrams) show an increase in the number of people who think they have the additional workload to justify a robot. As a result the number of people who would consider installing a robot to free up staff time has doubled.

At the same time, though, there is an increase in the number of people who consider robots a luxury item. This indicates pharmacists are agreed on how busy they are but becoming polarised on whether robots are the answer to their problems.

A. No, they're a luxury item

B. No, our workload doesn't warrant the cost

C. Yes, they'll free up staff time

CATEGORY MANAGEMENT

Advertisement feature

OTC Woundcare

FIRST AID FACTS

- **59% of first aid products are for a specific need – make sure the range you stock covers the key areas**
- **First aid is a household necessity and the home first aid kit needs to be kept topped up just in case – exploit impulse and link purchase opportunities**
- **Over 80% of shoppers buy only a single product – keep your fixture well stocked and signposted to maximise purchase opportunities**

Source: BDF Data 2006

Your customers expect to find a comprehensive selection of woundcare and related first aid lines in your pharmacy. But it can be a difficult category to effectively merchandise without a clear understanding of how and why customers buy woundcare products.

The first point to understand, according to the experts at Elastoplast, is purchasing behaviour. First aid products are bought to meet specific needs:

- Distress purchases for wounds or injuries (minor cuts, blisters etc) – 59% of purchases.
- Restocking the home first aid kit – 25% of purchases.
- Holiday purchases, fuelled by fear of unfamiliar health service and shopping environments – 16% of purchases.

Since 83% of shoppers chose the woundcare product they buy at the fixture, having a clear, well merchandised display is vital. They will look for a product that meets their specific needs and on average will spend 77 seconds at the fixture. Even 'browsers' will spend over 50 seconds looking over the category – an indication, perhaps, that they generally find it confusing, with a lot of duplication.

Top 6 merchandising guidelines

- A key objective is to merchandise your woundcare category to reflect the contents of a home first aid kit.
- Remember that first aid purchases in pharmacies are highly needs-led. Space restrictions may mean product choice is limited, but customers will generally expect to find something to meet every need.
- Ensure all similar products (plasters, bandages, antiseptics etc) are merchandised together.
- Signposting leading brands such as Elastoplast for plasters, and Savlon for antiseptics, can help guide shoppers to the appropriate section on-shelf.
- Keep product range concise, with duplication of brands within product types to a minimum, so as not to confuse shoppers.
- Where possible block products from the same brand together for greater visual impact.

The right shelf layout

Within the categories in your first aid section, subcategories and brands should be blocked horizontally, and product types vertically (see below). Within the blocks ensure that as far as possible you maintain a price flow from low to high (left to right).

MAKE THE LINK....

Locating related products with your OTC woundcare display will encourage link sales. Products such as those listed below are among the obvious partners for woundcare products in a first aid section:

- antiseptics
- bandages
- scissors
- strappings
- specialist dressings
- limb and joint supports
- pain relief sprays
- insect repellents
- sting relief creams.

Within the plasters/dressing sub-category the recommendation from Elastoplast is to group dressing types as shown below.

For Elastoplast products your Advanced range may include Spray Plaster, Burn Plaster and Spray and could lead with SilverHealing as the 'stepping stone' to buying advanced plasters.

Market drivers

Fabric and Waterproof plasters make up the majority of sales in the woundcare sector. However growth is being driven by advanced, spray and SilverHealing products, as consumers are trading up in to these more sophisticated offerings.

Elastoplast is the brand market leader, with over half the absolute growth in the category coming from this brand. Own label accounts for sales of £31.7m, but unit sales were down slightly in the 12 months to April 2007.*

As with many product categories, OTC woundcare has a seasonal peak, with unit sales of Elastoplast brands reaching a high of just under a million packs a month in July and August (based on 2006 figures), compared to around half that in November and December. Promotions will therefore see the biggest sales uplifts in the key months of May to August.

* Source IR. HBA outlets 52 w/e April 2nd 2007

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Yorkshire tales

Bon Viveur

In the early part of the 19th century, England was rocked by the violence of the Luddite riots. Driven by the harsh economic conditions that followed the Napoleonic wars and the introduction of new technologies and machinery occasioned by the Industrial Revolution, the Luddites' principal objection was to the introduction of new wide framed looms that could be operated by cheap, relatively unskilled labour with the resulting loss of employment for textile workers. Many wool and cotton mills were destroyed and the British government of Lord Liverpool harshly suppressed the movement, including using the army. At one time there were more troops fighting the Luddites than Napoleon on the Iberian Peninsula.

The disturbances were at their worst in the West Riding of Yorkshire and local magistrates were prominent in the government's efforts, none more so than Joseph Radcliffe, Lord of the Manor of Marsden and county magistrate for Huddersfield. As reward for his efforts he was awarded a Baronetcy by a grateful government and, shortly after that, expired. His son and heir, finding the grimy gloom of mill-mobbed Huddersfield beneath the status of a baronet, moved the family to the Rudding Park estate, just outside Harrogate, which was fast becoming popular as a spa for the English elite and nobility from all over Europe. As with so many such estates it fell on hard times between the wars and is now a hotel and leisure complex with a newly refurbished and much publicised restaurant. The New Blonde and I decided to try it.

> "Yorkshire tea yes, Yorkshire tapas...?"

The Clock Tower Restaurant is situated within the Rudding Park Hotel, accessed by a separate door and is a brown (the designer probably called it tobacco) and cream room with a rather startling cranberry glass chandelier. The room opens through French doors to an outside terrace and has a calm and relaxed ambiance.

Chef Stephanie Moon offers a rather confused menu which journeys from cottage pie and fish and chips to lobster thermidor and oriental sea bass without ever giving the impression of knowing its destination. One is also given, in addition to the menu and wine list, a menu of Yorkshire tapas! Yorkshire tea yes, Yorkshire tapas...?

After some difficulty, we chose starters of penne pasta with vegetables (and an unexpected bruschetta) and Whitby crab with pink grapefruit and lemon dressing. Both were tasty although the crab was somewhat haphazard in presentation. To follow, I had Yorkshire beef fillet, roast garlic, dauphinoise and a (completely inedible) glazed shallot. It was fine but not exceptional. NB had sea bass steamed with soy, garlic, bamboo shoots and noodles which also came with an unmentioned (and rather dire) oriental salad. The dish was a melange of unattractively presented ingredients and tasted of nothing much at all. Portions, as befits a county famous for parsimony, were value for money sized but would have been better with more attention to preparation and presentation.

The wine list is modishly (and foolishly) arranged into flavour style rather than provenance and contained no stars. But we did unearth a Château Potensac 2000, a Cru Bourgeois from the far north of the Medoc, which was excellent, full of ripe flavour and rounder in style than is typical of this region. This went well with a cleverly presented cheeseboard, complete with a small glass of port. **From next month Bon Viveur and Plonker will be moving online. Look out for more details on the back page.**

Would I go here again?
The money for quantity equation is typically Yorkshire but the quality really isn't there – so no.

What would I change?
The menu needs more focus to deliver a statement as to the chef's skills and intentions and the Luddite in me wants to smash the wine list!

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